

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4811 63-036246  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED SEP 18 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Gladstone	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital		d. STREET ADDRESS (If outside, give location) 1105 East 67 Terr. No.	

3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL LAURENCE JONES			4. DATE OF DEATH Month Day Year August 29, 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-23-1919	9. AGE (last birthday) 43	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage & Tow Service		10b. KIND OF BUSINESS OR INDUSTRY Emergency Tow Serv.		11. BIRTHPLACE (City and state or country) Clinton Co. Mo. U.S.A.	
13a. FATHER'S NAME Charles Allen Jones		13b. MOTHER'S MAIDEN NAME Susan A. Thompson		14. NAME OF HUSBAND OR WIFE Doris R. Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service yes W.W. II & Korea		16. SOCIAL SECURITY NO.		17. INFORMANT Doris R. Jones, 1105 E. 67th Terr. No.	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>My both kidneys + crushed lower</i> <i>backbone Bone marrow on</i> <i>at side abd</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>My both kidneys + crushed lower</i> <i>backbone Bone marrow on</i> <i>at side abd</i> DUE TO (c) <i>My both kidneys + crushed lower</i> <i>backbone Bone marrow on</i> <i>at side abd</i>		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>History of Infection</i>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>Truck trying to lift on</i> <i>men of 1100 lbs</i> <i>men of 1100 lbs</i> <i>men of 1100 lbs</i>	
20c. TIME OF INJURY Hour a.m. p.m. 8-29-63	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Highway</i>	20f. CITY, TOWN, OR LOCATION <i>Kansas City Jackson</i>
21. I attended the deceased from _____, to _____ and last saw her alive on _____. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <i>Dr. R. H. Owens</i>	(Degree or title)	22b. ADDRESS <i>153 Union Station</i>	22c. DATE SIGNED <i>8-30-63</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-31-63	23c. NAME OF CEMETERY OR CREMATORY White Chapel	23d. LOCATION (City, town, or county) Gladstone, Missouri

24. FUNERAL DIRECTOR Melody-McGilley-Eylar Antioch Chapel	25. DATE RECD. BY LOCAL REG. 8-30-63	26. REGISTRAR'S SIGNATURE <i>Bessie Smith</i>
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3325 Vivion Rd.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

H. OWENS MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James R. Phillips

Licensed Embalmer No. 4641

P. O. Address K.C. mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.